

State of New Hampshire						For Internal Use Only				
Family Health Statement			Employer/Group Name			Group Number		Effective Date / /		
Please print clearly and complete this form in black ink. Please provide all requested information for each person eligible to be covered.										
Employee Name: (First)			(M.I.)		(Last)			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		
Home Address:			City			State		Zip		
Indicate the type of coverage you are applying for:			<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee-Spouse		<input type="checkbox"/> Employee-One Child <input type="checkbox"/> Employee-Children		<input type="checkbox"/> Employee-Family (spouse & children)			
Part 1 - EMPLOYEE/DEPENDENT INFORMATION – List yourself and all eligible dependents to be covered.										
Relation	Sex	Last Name	First Name	M.I.	Social Security Number	Height	Weight	Disabled	Full-time Student	Date of Birth
employee	<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N		_/_/_
	<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_/_/_
	<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_/_/_
	<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_/_/_
	<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_/_/_
	<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_/_/_
Part 2 - WAIVER/REFUSAL OF COVERAGE – You MUST complete this section if any person is waiving (declining) this health insurance.										
I have been given the opportunity to apply for group health coverage available to me and my dependents through the above named employer.										
<div style="display: flex; justify-content: space-between;"> <div> I hereby waive group coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependent Children </div> <div> I waive group coverage because: <input type="checkbox"/> Spousal Coverage <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Individual Health Coverage <input type="checkbox"/> Coverage under another carrier's plan provided by the above named employer <input type="checkbox"/> Other _____ </div> </div>										
I have declined coverage of my own free will without inducement or pressure by my employer, the producer or health insurer. I understand if I and/or my spouse and/or my dependent children waive coverage and desire to participate in the plan at a later date, we may be treated as late enrollees and required to wait until the plan's next scheduled open enrollment period to enroll.										
Employee Signature _____ Date _____										
If you have waived coverage and signed above – Do not complete the rest of this Family Health Statement.										
Part 3 - HEALTH INFORMATION – The information collected on this form will be used for premium rating purposes only. You will not be denied coverage based on your health status. Please provide all requested information for each person to be covered.										
1. Has any person to be covered by this plan ever had indications of, been diagnosed with, treated for, or had treatment recommended for any of the following conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then place a check beside the condition and provide details in the Medical Details Section in Part 4.										
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;">A. <input type="checkbox"/> Benign tumor</div> <div style="width: 33%;">D. <input type="checkbox"/> Connective Tissue Disease (Marfans or variant)</div> <div style="width: 33%;">F. <input type="checkbox"/> Heart disease, Angina</div> <div style="width: 33%;">B. <input type="checkbox"/> Blood or circulatory problems</div> <div style="width: 33%;">E. <input type="checkbox"/> Heart attack</div> <div style="width: 33%;">G. <input type="checkbox"/> Liver condition</div> <div style="width: 33%;">C. <input type="checkbox"/> Cancer</div> <div style="width: 33%;"></div> <div style="width: 33%;">H. <input type="checkbox"/> Stroke</div> </div>										
2. Has any person to be covered by this plan had indications of, been diagnosed with, treated for, or had treatment recommended for any of the following conditions listed in this question and question 3 below within the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then place a check beside the condition and provide details in the Medical Details Section in Part 4.										
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;">A. <input type="checkbox"/> Colitis or intestinal condition</div> <div style="width: 33%;">D. <input type="checkbox"/> Gall bladder disease or gall stones</div> <div style="width: 33%;">H. <input type="checkbox"/> Paralysis</div> <div style="width: 33%;">B. <input type="checkbox"/> Disease of eyes, ears, nose, or throat</div> <div style="width: 33%;">E. <input type="checkbox"/> Kidney disease or kidney stones</div> <div style="width: 33%;">I. <input type="checkbox"/> Reproductive System Disorders/Infertility</div> <div style="width: 33%;">C. <input type="checkbox"/> Disorders of spine, discs, joints</div> <div style="width: 33%;">F. <input type="checkbox"/> Lung condition or tuberculosis</div> <div style="width: 33%;">J. <input type="checkbox"/> Thyroid or goiter</div> <div style="width: 33%;">Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div style="width: 33%;">G. <input type="checkbox"/> Muscle/nervous system disorder</div> <div style="width: 33%;">K. <input type="checkbox"/> Ulcers, Reflux, Gerd or other stomach conditions</div> <div style="width: 33%;">Date of surgery _____</div> </div>										
3. <div style="display: flex;"> <div style="width: 50%;"> A. <input type="checkbox"/> Alcohol or <input type="checkbox"/> Drug Abuse/Addiction <input type="checkbox"/> Inpatient: Dates treated _____ <input type="checkbox"/> Outpatient: Dates treated _____ </div> <div style="width: 50%;"> E. <input type="checkbox"/> Emotional or mental health conditions: Diagnosis/Condition: _____ <input type="checkbox"/> Inpatient Dates of admission: _____ <input type="checkbox"/> Outpatient # of visits within the last 12 months _____ Medication used within the last 12 months _____ Medication was prescribed by: <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Family Physician Date medication last used _____ </div> </div> <div style="display: flex;"> <div style="width: 50%;"> B. <input type="checkbox"/> Arthritis or Rheumatism: Type _____ Medication used within the last 12 months _____ </div> <div style="width: 50%;"> F. <input type="checkbox"/> Epilepsy or Seizures: Type and date of last seizure _____ Medication used within the last 12 months _____ </div> </div> <div style="display: flex;"> <div style="width: 50%;"> C. <input type="checkbox"/> Asthma or <input type="checkbox"/> Other respiratory conditions: Frequency of attacks _____ Date of last attack _____ Dates of any hospitalizations _____ Medication used within the last 12 months _____ How often taken _____ </div> <div style="width: 50%;"> G. <input type="checkbox"/> High blood pressure: Last reading and date _____ Medication used within the last 12 months _____ </div> </div> <div style="display: flex;"> <div style="width: 50%;"> D. <input type="checkbox"/> Diabetes: <input type="checkbox"/> Diet <input type="checkbox"/> Oral medication or <input type="checkbox"/> Insulin controlled </div> <div style="width: 50%;"> H. <input type="checkbox"/> Lupus: <input type="checkbox"/> Systemic <input type="checkbox"/> Discoid </div> </div>										

Employer Group Name							
Part 3 - HEALTH INFORMATION – continued							
4. Has any person to be covered by this plan ever been diagnosed with or tested positive for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then provide details in the Medical Details Section in Part 4.							
5. Is any person listed Part 1 of this form currently pregnant or an expectant parent? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then provide details in the Medical Details Section in Part 4.							
6. Has any person to be covered by this plan been advised to have future medical treatment or surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then provide details in the Medical Details Section in Part 4.							
7. Has any person to be covered by this plan used tobacco products in any form within the past 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, provide user's name(s) _____ and date(s) of last use _____.							
8. Has any person to be covered by this plan taken any prescription drugs not already noted within the past 5 years for any illness, injury or condition (excluding colds, flu and routine exams not related to a medical condition)? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then provide details in the Medical Details Section in Part 4.							
9. Has any person to be covered by this plan been examined or treated by a physician, psychotherapist, counselor, or other medical professional within the past 5 years for any illness, injury or condition not already noted (excluding colds, flu and routine exams not related to a medical condition)? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, then provide details in the Medical Details Section in Part 4.							
Part 4 - MEDICAL DETAILS – Please provide complete details for all YES answers in Part 3. Attach additional sheets if necessary.							
Question Number	Family Member's Name	Condition or Reason	Treatment and/or Medication	Onset Date	Recovery Date	Degree of Recovery	Treating Physician Name, Address and Telephone
Part 5 - FAMILY HEALTH STATEMENT CERTIFICATION							
I represent that all statements and answers I have given are complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I will promptly inform the insurance carrier in writing before my coverage takes effect if I become aware that anything has occurred that makes this family health statement incomplete or incorrect. I understand that I or any other adult to be covered by this policy may be contacted for additional information or asked to sign an authorization for the release of medical records. Health care providers listed on this form will not be contacted unless you or your dependent signs a separate written medical authorization.							

Employee Printed Name

Employee Signature

Date

Daytime Phone Number